Stable Life Counseling Center, LLC
Shirley B Johnson, M.Ed., LBSW, LPC
Phone: (361) 485-0899

IMPORTANT INFORMATION AND CLIENT CONSENT: Please read, initial in appropriate places, and sign at the end stating you have fully read and understand the information below.

STABLE LIFE COUNSELING CENTER, LLC is owned by Shirley B Johnson, M.Ed., LBSW, LPC, an independent licensed mental health practitioner. Thank you for selecting us for your counseling needs. Always remember that if at any time you any questions or comments, feel free to voice them to us.

CLIENT/THERAPIST RELATIONSHIP: You and your Therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your Therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Therefore, we cannot approach you when we are in public nor can we discuss your issues at that time, but you are more than welcome to greet us.

AVAILABLE SERVICES: Stable Life Counseling Center, LLC offers in-person and phone counseling at this time. We are staffed by a skilled and experienced licensed professional counselor. Effective psychotherapy is based on mutual understanding and good rapport between client and therapist. It is our intent to convey the policies and procedures used in our practice, and we will be pleased to discuss any questions or concerns you may have.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are possible risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. We cannot guarantee these benefits, of course. It is our desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

COUNSELING: We provide short-term counseling designed to address many of the issues our clients are dealing with. Your first visit will be an assessment session in which you and your Therapist will determine your concerns and, if you both agree that she can meet your therapeutic needs, develop a plan of treatment. Should you choose not to follow the plan of treatment provided to you by your Therapist, services to you may be terminated.

The goal of Stable Life Counseling Center, LLC is to provide the most effective therapeutic experience available to you. If at any time you feel that you and your current Therapist are not a good fit, please discuss this matter with your Therapist to determine if transferring to a more suitable Therapist is right for you. If you and your Therapist decide that other services would be more appropriate, we will assist you in finding a provider to meet your needs.

APPOINTMENTS: Appointments are typically scheduled on a bi-weekly basis and are approximately 30 to 60 minutes long. **Appointments can be scheduled by calling 361-485-0899 or going online to stablelifecounseling.com.** More frequent sessions or an intensive outpatient schedule are available if determined appropriate by your Therapist.

If you must cancel or reschedule your appointment, we ask that you call our office at 361-485-0899 at least 24 hours in advance, whenever possible. This will free your appointment time for another client. **If you are a "no show" for an appointment (do not give 24-hour notice for an appointment cancellation), and you had a set appointment for each week, you may no longer have that day and/or time. Please call to schedule your next appointment. If you have two or more "no shows" (do not cancel 24 hours in advance), we have the right to no longer provide services to you.**

If you have a caseworker or probation officer, I have faxed a copy of the "no show" memo to him/her. It is my understanding that if you are with CPS and have two or more "no shows", then you run the risk of still having to attend counseling but paying full price for the sessions yourself.

I have read the above and agree. (initials)_________

FEE SCHEDULE Per SESSION (no matter how many people are in the session):

Service	Fee
Diagnostic & Evaluation Interview (1st visit) (90801)	$ 75
Individual Office or Phone Visit (25 minutes) (90804)	$ 40
Individual Office or Phone Visit (50 minutes) (90806)	$ 75
Interactive Office Visit (25 minutes) (Play Therapy, EAP) (90810)	$ 40
Interactive Office Visit (50 minutes) (Play Therapy, EAP) (90812)	$ 75
Outside Office Work (inpatient visits, court, collaborative law services)	$ 75/hr
Written Reports (insurance companies, supervisors, etc.) pro-rated at	$ 75/hr
Returned check fee per check	$ 25

A $.25 per page fee will be charged for copies of any records requested by the Client.

PAYMENT/INSURANCE FILING: As of **1/30/12**, only **PRIVATE PAY** is accepted, which is $75.00 per session hour and is due BEFORE the session starts unless it is a phone session, which we charge AFTER the session. If you have insurance, call them for pre-authorization and be prepared to pay for your session when you come. We'll give you an invoice to submit to your insurance company. We apologize for this inconvenience but the struggle for reimbursement from the insurance companies and clients walking out without paying is requiring us to do this.

If you would like for us to charge your debit or credit card at each session, please complete the following:

___MasterCard ___VISA ___Debit ___Credit #_______/________/________/________ Exp Date____/_____

CID #:______ (on back) Zip Code:_______________ Name on Card: _____________________________________

Signature___________________________________

EMERGENCIES: You may encounter a personal emergency which will require prompt attention. In this event, please contact our office regarding the nature and urgency of the circumstances. We will make every attempt to schedule you as soon as possible or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, we will make every effort to respond to your emergency in a timely manner. If your emergency arises after hours or on a weekend, your Therapist will be contacted by the answering service and your Therapist will call you back as soon as possible. If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help. When your Therapist is out of town, there will be another therapist from Stable Life Counseling Center, LLC on-call to help you.

CONFIDENTIALITY: Stable Life Counseling Center, LLC follows all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a Therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is an issue; situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of the Therapist when you and the Therapist discuss this matter further. By signing this Information and Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentiality that may result.

DUTY TO WARN/DUTY TO PROTECT: If my Therapist believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my Therapist to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. **I also give consent to my Therapist to contact the person(s) listed on the Intake Form in addition to any medical or law enforcement personnel deemed appropriate.**

I have read the above and agree. (initials)_________

INCAPACITY OR DEATH: I understand that, in the event of the death or incapacitation of the undersigned Therapist, it will be necessary to assign my case to another Therapist and for that Therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by the undersigned Therapist, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

CONSENT TO TREATMENT: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, we will not render services to your child until the Therapist has received and reviewed a copy of the most recent applicable court order.

I hereby consent to treatment by specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

STAFFING: I authorize the therapists of Stable Life Counseling Center, LLC to staff my or my child's case if the need arises.

I have read the above and agree.

____ _______________________________
Signature – Client/Parent Date

____ _______________________________
Signature – Spouse/Partner/Parent Date

____ _______________________________
Therapist Date

CONSENT FOR TREATMENT OF A MINOR

We/I, the undersigned _____________________________________, parent(s) and/or guardian(s) of a minor child _______________________________________, give you full and unconditional authority to proceed with a clinical evaluation and treatment as your judgment indicates. This consent is given by me/us as parent(s) and/or guardian(s) of said child. We/I have legal power to consent to medical, psychological, and mental health assessment and treatment of said minor child. It is clearly understood that you are hereby fully released from any claims and demands that might arise, or be incident to the evaluation and/or treatment, provided that your duties are performed with standard care and responsibility to the best of your professional ability.

Signed this ____day of __________, 20__

_______________________________ _______________________________
Mother or Guardian Father or Guardian